

## NOTICE OF INDEPENDENT REVIEW DECISION

July 25, 2002

RE: MDR Tracking #: M2-02-0929-01  
IRO Certificate #: 4326

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to \_\_\_ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

\_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a \_\_\_ physician reviewer who is board certified in orthopedic surgery which is the same specialty as the treating physician. The \_\_\_ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to \_\_\_ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

### Clinical History

This 34 year old female sustained a work-related injury on \_\_\_ when she was picking up chairs and experienced neck and right arm pain. An MRI of the lumbar spine was reported as normal and an MRI of the cervical spine indicates two bulges. The patient continues to complain of pain and discomfort and the treating orthopedist has recommended that the patient undergo CT myelogram of the lumbar and cervical spine.

### Requested Service(s)

CT myelogram of the lumbar and cervical spine

### Decision

It is determined that the CT myelogram of the lumbar and cervical spine is not medically necessary to treat this patient's condition.

### Rationale/Basis for Decision

Based on the medical information provided for review, it appears that this patient is experiencing overload inflammatory arthrosis of the lower facet joints and sacroiliac joints. This is a very common problem that is frequently missed by treating physicians. The treatment for this condition is manual therapy performed by an experienced spine therapist who can mobilize these overloaded areas. This patient should be evaluated by a trained spine therapist and not undergo further testing in the form of a cervical and lumbar CT myelogram. Therefore, it is determined that a CT myelogram of the lumbar and cervical spine is not medically necessary at this time.

This decision by the IRO is deemed to be a TWCC decision and order.

### **YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

-----  
**If disputing a spinal surgery prospective decision** a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) days of your receipt of this decision (20 Tex. Admin. Code 142.5(c)).

**If disputing other prospective medical necessity (preauthorization) decisions** a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,